U.S. Department of State

# SPECIAL SEATING REQUEST FORM FOR BUSINESS CLASS AIR TRAVEL

**For Employee's Special Needs** ***(See 14 FAM 567.2-4)***

Employee Name _____
Last First Middle

Organization Millennium Challenge Corporation

**Name of Attendants if Required:**

Name _____
Last First Middle

Name _____
Last First Middle

Name _____
Last First Middle

**Approved By:** ***(Check if M/MED or Identify POST)***

☐ M/MED ☐ POST _____
*(Print Name)*

_____
Signature of M/MED or RMO/FSNP

_____
Print Name of Approving Official

Date signed *(mm-dd-yyyy)* _____

Expiration date *(mm-dd-yyyy)* _____

**AUTHORITY WILL EXPIRE AS INDICATED ABOVE BY THE COMPETENT MEDICAL AUTHORITY.**

DS-4086
10-2005

Submit

U.S. Department of State

# BUSINESS CLASS UPGRADE - MEDICAL QUESTIONNAIRE

## For the traveler

(a) Release of information - Please sign and date the authorization printed for release of information from your physician.
"I hereby authorize my physician to provide the information requested below to the Domestic Programs, Office of Medical Services, U.S. Department of State and to provide requested information verbally and in writing regarding my medical or mental health condition(s) as it pertains to my request for a premium travel upgrade".

Traveler's Signature _____ Date *(mm-dd-yyyy)* _____

Traveler's Name *(Last, First, MI)* _____

Home Address _____ City _____ State _____ ZIP Code _____

Work Phone _____ Home Phone _____

Primary Email _____ Secondary Email _____

(b) Traveler Statement - On the next page, you may explain your specific difficulties requiring business class or a premium travel upgrade.

(c) Have your physician document the information requested and sign this form. Alternatively, the information can be provided on signed letterhead.

(d) Email this form as a scanned pdf attachment to medDP@state.gov. Alternatively, it can be faxed to attention: Domestic Programs, 202-663-1687.

Traveler Statement

Please take this form to your treating physician.

Your patient is requesting business class travel or a premium travel upgrade for a medical condition. Determinations are on the basis of a medical need, not traveler comfort. We are requesting your assistance in determining if your patient has a medical condition necessitating business class travel.

Please provide the following information:

1) Diagnosis and current medical condition of your patient.

2) Current treatment regimen for this condition including current medications.

3) What impact would air travel likely have on your patient if no special accommodations were made?

4) Which of the following modalities may your patient use during commercial air travel? *(Please check each one that applies.)*

- ☐ a. Frequent standing
- ☐ b. Walking and moving about the cabin
- ☐ c. Frequent in-seat stretching
- ☐ d. The use of support stockings (*thigh high or full length*)
- ☐ e. Aisle seating
- ☐ f. Exit row seating
- ☐ g. Bulkhead seating
- ☐ h. Medications

5) If your patient utilized the above modalities, how would your patient likely be affected by air travel? What, if any, adverse effects would your patient be likely to have as a result of air travel while using the above modalities?

6) If the modalities noted in number 4 were available to your patient, please specify what, if any, additional accommodation/modalities you recommend for air travel? What, if any, adverse effect is your patient likely to have as a result of air travel using the additional modalities you recommend?

7) Do you recommend business class travel for your patient? If so, why and what is accomplished by business class travel that is not accomplished by the modalities noted in number 4?

8) Does duration of travel affect your patient's medical condition with or without the accommodation? If so, is there any length or type of travel that you recommend that your patient not undertake because it would adversely affect his/her medical condition?

9) What is the patient's prognosis? How long is the current medical condition expected to last?

10) Please provide any additional information supporting your recommendation. *(Please forward copies of reports, x-ray results and laboratory tests.)*

11) Please sign and date this form as follows:

Physician's Signature _____ Date *(mm-dd-yyyy)* _____

Physician's Printed or Typed Name and Degree _____ Phone _____

Address _____

City _____ State _____ ZIP Code _____

To the Doctor: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law we are asking that you NOT provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.